

PATIENT RECORDS REQUEST FORM

Sewee Dental Care
2928 Hwy 17 N
Mt. Pleasant, SC 29466
Phone 843-856-8856 / Fax 843-856-8814

Name of Patient Whose Record is Requested _____

DOB _____ Phone _____

Address _____ City/State/Zip _____

Please provide a copy of the record as indicated below:

- The full health record maintained by this provider/practice
- The health record for the following time frame: _____ through _____
- A specific section of the health record as described below:

- A summary of the information requested above is adequate to fulfill this request.
- As permitted by federal and state law, I understand that a fee of _____ cents per page will be charged for copying the records along with a clerical fee of _____. In addition, a fee of _____ will be charged for any duplication of x-rays. I agree to pay this charge in full at the time I receive the copy of the record.

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date _____